EXHIBIT A

Posttraumatic Stress Disorder: Residential Care

MCG™
Behavioral Health Care
17th Edition

ORG: B-013-RES (BHG)
Link to Codes

Residential Care Admission and Alternatives

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Clinical Indications for Admission to Residential Care

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[Expand All / Collapse All]

- Admission is indicated because of **1 or more** of the following:
  - Admission to Residential Acute Level of Care is judged appropriate as indicated by **ALL** of the following [A]:
    - Around-the-clock behavioral care is necessary for treatment because of **1 or more** of the following:
      - Imminent danger to self because of **1 or more** of the following(1)(4)(5)(6):
        - Imminent risk for recurrence of Suicide attempt or act of serious self Harm as indicated by **ALL** of the following:
          - Very recent Suicide attempt or deliberate act of serious self Harm
          - Absence of Sufficient relief of the action's precipitants
        - Current plan for suicide or serious self Harm
        - Command auditory hallucinations for suicide or serious self Harm
        - Persistent Thoughts of suicide or serious Harm to self, or suicide trigger state without formed thoughts, that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B](7)(8):
          - Insufficient behavioral care (eg, facility, provider) availability
          - Inadequate patient support system
          - Patient characteristics such as high impulsivity, unreliability, or extreme agitation with desperation
          - Ruminative flooding; uncontrollable and overwhelming profusion of negative thoughts
          - Frantic hopelessness; fatalistic conviction that life will not improve along with oppressive sense of entrapment and doom
      - Imminent danger to others due to **1 or more** of the following(5)(9)(10)(11):
        - Imminent risk for recurrence of an attempt to seriously Harm another as indicated by **ALL** of the following:
          - Very recent attempt to seriously Harm another
          - Absence of Sufficient relief of the action's precipitants
        - Current plan for homicide or serious Harm to another
        - Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious Harm to another
        - Persistent thoughts of homicide or serious Harm to another that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B]:
          - Insufficient behavioral care (eg, facility, provider) availability
          - Inadequate patient support system
          - Patient characteristics such as high impulsivity or unreliability
      - Life-threatening inability to perform self-care activity (eg, self neglect with inability to provide for self at lower level of care) (9)(10)
      - Severe disability or disorder requiring acute residential intervention as indicated by **ALL** of the following:

- Severe behavioral health disorder-related symptoms or condition are present as indicated by **1 or more** of the following(4)(5)(12)(13)(14):
  - Major dysfunction in daily living (eg, social, interpersonal, occupational functioning)
  - Severe problem with cognition, memory, or judgment(15)
  - Severe symptoms (eg, hallucinations, delusions, other acute psychotic symptoms, mania, extreme agitation or anxiety)(16)(17)
- Patient management at highest nonresidential level of care has failed or is not feasible until acute intervention or modification is initiated.
- Severe comorbid substance use disorder that must be controlled (eg, abstinence necessary) to achieve stabilization of primary psychiatric disorder(9)(18)(19)(20)
- Patient has currently stabilized during inpatient treatment stay for severe symptoms or behavior and requires structured setting with continued around-the-clock behavioral care.

- No exclusions to treatment; situation and expectations are appropriate for level as indicated by **ALL** of the following(1)(2)(3)(5)(9)(13)(4)(14):
  - Recommended treatment is necessary, appropriate, and not feasible at a lower level of care (ie, documented behavior, symptoms, or risk judged not appropriate for partial hospital, IOP, or acute outpatient care).
  - Very short-term crisis intervention and resource planning for further care at a nonresidential level is unavailable or judged inappropriate.
  - Patient is willing to participate in treatment within a highly structured setting voluntarily.
  - No anticipated need for physical restraint, seclusion, or other involuntary control (eg, patient not actively violent)
  - No need for around-the-clock medical or nursing care
  - Patient has sufficient cognitive capacity to respond to planned individual and group treatment components.
  - Adequate response (eg, stabilization for nonresidential level of care) to planned treatment is expected within a limited time period.

⊟ Admission to Residential Acute Level of Care for Child or Adolescent is judged appropriate as indicated by **ALL** of the following [A]:

- Around-the-clock behavioral care is necessary for treatment because of **1 or more** of the following(21):
  - Imminent danger to self because of **1 or more** of the following(6)(22)(23):
    - Imminent risk for recurrence of Suicide attempt or act of serious self Harm as indicated by **ALL** of the following:
      - Very recent Suicide attempt or deliberate act of serious self Harm
      - Absence of Sufficient relief of the action's precipitants
    - Current plan for suicide or serious self Harm
    - Command auditory hallucinations for suicide or serious self Harm
    - Dangerous behavior risk, persistent Thoughts of suicide or serious Harm to self, or suicide trigger state without formed thoughts, that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B](8)(22):
      - Insufficient child or adolescent behavioral care (eg, facility, provider) availability
      - Severe conflict in family environment or other inadequacy in patient support system
      - Patient characteristics such as high impulsivity, unreliability, or extreme agitation with desperation
      - Ruminative flooding; uncontrollable and overwhelming profusion of negative thoughts
      - Frantic hopelessness; fatalistic conviction that life will not improve along with oppressive sense of entrapment and doom
  - Imminent danger to others due to **1 or more** of the following(5)(10)(11)(24):
    - Imminent risk for recurrence of an attempt to seriously Harm another as indicated by **ALL** of the following:
      - Very recent attempt to seriously Harm another
      - Absence of Sufficient relief of the action's precipitants
    - Current plan for homicide or serious Harm to another
    - Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious Harm to another
    - Persistent thoughts of, or violent impulsive acts that could likely result in, homicide or serious Harm to another that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B]:
      - Insufficient child or adolescent behavioral care (eg, facility, provider) availability
      - Severe conflict in family environment or other inadequacy in patient support system
      - Patient characteristics such as high impulsivity or unreliability
  - Life-threatening inability to receive adequate care from caretakers(5)(10)
  - Severe disability or disorder requiring acute residential intervention as indicated by **ALL** of the following:
    - Severe behavioral health disorder-related symptoms or condition are present as indicated by **1 or more** of the following(2)(3)(5)(12)(13)(14):
      - Major dysfunction in daily living (eg, family, interpersonal, school functioning)
      - Severe problem with cognition, memory, or judgment
      - Severe symptoms (eg, hallucinations, delusions, other acute psychotic symptoms, mania, severe autistic behaviors)(16)(17)(25)
      - Severe behavior risk (affective dysregulation) characteristics indicated by **1 or more** of the following:
        - Evidence of severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
        - Frequent extreme external (extreme angry outbursts) or internal (extreme sulking and rumination) anger manifestations
        - High levels of family conflict
    - Patient management at highest nonresidential level of care has failed or is not feasible until acute intervention or modification is initiated.

- Severe comorbid substance use disorder that must be controlled (eg, abstinence necessary) to achieve stabilization of primary psychiatric disorder(19)(20)
- Patient has currently stabilized during inpatient treatment stay for severe symptoms or behavior and requires structured setting with continued around-the-clock behavioral care.

- No exclusions to treatment: situation and expectations are appropriate for level as indicated by **ALL** of the following(1)(2)(3)(5)(9)(13)(21)(22):
  - Recommended treatment is necessary, appropriate, and not feasible at a lower level of care (ie, documented behavior, symptoms, or risk judged not appropriate for partial hospital, IOP, or acute outpatient care).
  - Very short-term crisis intervention and resource planning for further care at a nonresidential level is unavailable or judged inappropriate.
  - Patient has, at the least, minimal motivation to participate in treatment within a highly structured setting at the direction of parent or guardian.
  - No anticipated need for physical restraint, seclusion, or other involuntary control (eg, patient not actively violent)
  - No need for around-the-clock medical or nursing care
  - Patient has sufficient cognitive capacity to respond to planned individual and group treatment components.(14)
  - Adequate response (eg, stabilization for nonresidential level of care) to planned treatment is expected within a limited time period.

Alternatives to Admission

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- Alternatives include(4)(7)(26)(27):
  - Acute outpatient care: appropriate if around-the-clock behavioral care is not necessary, and needed type and frequency of treatment are available in office or clinic setting.(28)(29)(30)(31) See Posttraumatic Stress Disorder: Acute Outpatient Care BHG.
  - Intensive outpatient program: appropriate if around-the-clock behavioral care is not necessary, and needed type and frequency of treatment are available in intensive outpatient program but not in office or clinic setting.(32)(33) See Posttraumatic Stress Disorder: Intensive Outpatient Program BHG.
  - Partial hospital program: appropriate if around-the-clock behavioral care is not necessary, and support is available to provide any needed monitoring of patient's condition when partial hospital program is closed.(32)(34)(35) See Posttraumatic Stress Disorder: Partial Hospital Program BHG.
  - Care for higher-risk or more severely ill patient in inpatient care. See Posttraumatic Stress Disorder: Inpatient Care BHG.

Alternative Care Planning

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- Care planning needs for patient not requiring residential admission may include:
  - Prompt visit to a psychiatrist for assessment and possible pharmacotherapy [C] (29)(36)(37)(38)(39)(40)
  - Referral for trauma-focused individual psychotherapy [D] (29)(42)(43)(44)(45)(46)(47)
  - Medical care visit (eg, primary care) to evaluate comorbidity or clear for pharmacotherapy
  - Discharge planning as appropriate. See Discharge Planning in this guideline.

Residential Care Treatment

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Recovery Course

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Stage	Clinical Status	Interventions	Medications	Evaluation	Therapy
1	• Clinical indications met [E] • Begin discharge planning	• Possible frequent safety checks [F]	• Possible antidepressant [C]	• Exploration of admission precipitants [G] • Psychiatric, social, medical, substance use, and traumatic events histories [H] • Mental status and physical examinations • Symptoms assessed multiple times per shift	• Psychosocial interventions emphasizing admission precipitants [I] (daily)

2		• Possible frequent safety checks	• Medication review if prescribed	• **Evaluation completed and reviewed** • Symptoms assessed multiple times per shift	• Psychosocial interventions emphasizing admission precipitants (daily) • Clinical management and psychoeducation if medication is prescribed [J] (every other day) • Parental component of psychosocial interventions if patient is child or adolescent (every third day)
3	• **No plan [K] for suicide or serious self-harm [L] for at least 24 hours**	• No need for frequent safety checks	• Medication review if prescribed	• Transition to patient check-in with staff	• Psychosocial interventions emphasizing barriers to discharge [I] (daily) • Clinical management and psychoeducation if medication is prescribed (every other day) • Parental component of psychosocial interventions if patient is child or adolescent (every third day)
4	• **Risk status acceptable** • **Functional status acceptable** • Complete discharge planning • Discharge	• Review follow-up treatment and crisis plan with patient and supports [M]	• **Medical needs manageable**		

(9)(28)(29)(30)(32)(36)(37)(39)(50)(51)

Recovery Milestones are indicated in **bold**.

Residential Care Planning

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- Residential evaluation and care needs may include:
  - Diagnostic test scheduling and completion, including [N] (49):
    - Urine drug screen [H]
    - Pregnancy test
  - Treatment and procedure scheduling and completion, including:
    - Psychosocial interventions emphasizing admission precipitants and barriers to discharge [I]
    - Clinical management and psychoeducation if medication is prescribed [J]
    - Parental component of psychosocial interventions if patient is child or adolescent(29)
    - Trauma-focused individual psychotherapy [D] [O]
    - Antidepressant medication [C]
  - Consultation, assessment, and other services scheduling and completion, including:
    - Substance abuse assessment(28)
    - Social services consultation for placement or housing
    - Conference with school for child or adolescent
  - Monitoring patient's status for deterioration and comorbid conditions; key items include:
    - Psychiatric comorbidity [H]
    - Substance withdrawal
    - Pre-existing medical comorbidity

Discharge Criteria

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- Continued residential care is generally needed until 1 or more of the following(9):
  - Residential care no longer necessary due to adequate patient stabilization or improvement as indicated by **ALL** of the following(4)(7)(26)(27)(28):

- Risk status acceptable as indicated by **ALL** of the following:
  - Patient has not recently made a Suicide attempt or act of serious self Harm , or has had Sufficient relief of precipitants of any such action.
  - Absence of Current plan for suicide or serious self Harm for at least 24 hours
  - Thoughts of suicide , homicide, or serious Harm to self or to another are absent or manageable at available lower level of care.
  - Patient and supports understand followup treatment and crisis plan.
  - Provider and supports are sufficiently available at lower level of care.
  - Patient can participate (eg, verify absence of plan for harm) in needed monitoring.
- Functional status acceptable as indicated by **1 or more** of the following:
  - No essential function [F] is significantly impaired.
  - An essential function is impaired, but impairment is manageable at available lower level of care.
- Medical needs manageable as indicated by **ALL** of the following:
  - Adverse medication effects absent or manageable at available lower level of care
  - Medical comorbidity absent or manageable at available lower level of care
  - Substance withdrawal absent or manageable at available lower level of care
- Residential care no longer appropriate due to patient progress record or consent as indicated by **1 or more** of the following:
  - Patient deterioration requires higher level of care.
  - Patient or guardian no longer consents to treatment.

Discharge

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Discharge Planning

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- Discharge planning needs may include(51):
  - Rapid decision and planning regarding next level of care; considerations include:
    - Plan for monitoring for dangerous ideation or behavior if necessary(7)(26)
    - Plan for assisting patient with self-care if necessary
  - Follow-up plan development with input from multiple providers, patient, and patient's supports(28)
  - Preparation of patient and supports for transition to lower level of care, including:
    - Ensure sufficient knowledge of(28)(29):
      - Patient's illness
      - Medication
      - Risk factors for relapse
      - Warning signs of relapse
    - Assess ability to work, attend school, and participate in usual activities.
    - Review crisis plan with patient and supports. [M]
    - Patient and caregiver education complete. See Posttraumatic Stress Disorder: Patient Education for Clinicians SR.
  - Follow-up appointments, including:
    - Psychiatrist for pharmacotherapy and clinical management [C]
    - Therapist for trauma-focused psychotherapy [C]
    - Medical care visit (eg, primary care)
  - Referrals for community assistance and support, including:
    - Self-help or support groups for patient, family, and caregivers(28)
    - Community services for housing, financial, or transportation needs
  - Discharge medications and supplies, including:
    - Antidepressant medication
    - Medications for comorbid medical conditions

Discharge Destination

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Usual

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- Acute outpatient care. See Posttraumatic Stress Disorder: Acute Outpatient Care BHG.

Alternate

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- Intensive outpatient program: appropriate if around-the-clock behavioral care is not necessary, and needed type and frequency of treatment are available in intensive outpatient program but not in office or clinic setting. See Posttraumatic Stress Disorder: Intensive Outpatient Program BHG.
- Partial hospital program: appropriate if around-the-clock behavioral care is not necessary, and support is available to provide any needed monitoring of patient's condition when partial hospital program is closed. See Posttraumatic Stress Disorder: Partial Hospital Program BHG.

Annotated Bibliography

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See Posttraumatic Stress Disorder - Annotated Bibliography BHG for a discussion of key literature.

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Footnotes

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[A] Residential care is intended for patients who need around-the-clock behavioral care but do not need the high level of physical security and frequency of psychiatric and medical intervention that are available on an inpatient unit.(1)(2)(3) [A in Context Link 1, 2]

[B] Patients with persistent thoughts of suicide, homicide, or serious harm to self or another may need frequent monitoring for progression to planning or intention to act on their thoughts. Such monitoring can be safely conducted at an outpatient level of care if providers and supports are available and the patient can reliably participate in the monitoring process.(7) [B in Context Link 1, 2, 3, 4]

[C] In adults, randomized controlled trials have found that a variety of antidepressants from multiple medication classes are efficacious, with greatest efficacy demonstrated for SSRIs.(29)(36)(37)(38) A meta-analysis of studies examining the atypical antipsychotics olanzapine and risperidone in PTSD, either as monotherapy or as adjunctive pharmacotherapy, found them superior to placebo, although side effects, including weight gain, led to substantial dropout rates among those treated.(39) A randomized controlled trial of a pharmacotherapy for PTSD in children and adolescents compared sertraline and trauma-focused cognitive behavioral therapy (CBT) vs trauma-focused CBT alone and did not find that the combination therapy was more efficacious.(40) An expert consensus guideline recommends that an antidepressant be used to treat PTSD in a child or adolescent only if trauma-focused CBT has been unsuccessful.(29) [C in Context Link 1, 2, 3, 4]

[D] For PTSD in adults, meta-analyses of randomized controlled trials have found that individually administered as well as group trauma-focused cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing therapy were effective.(29)(41)(42)(43) A meta-analysis shows prolonged exposure therapy to be similarly effective.(44) A meta-analysis and systematic review of CBT for the treatment of PTSD in children

report that CBT was efficacious in this patient population.(45) A meta-analysis and systematic review of cognitive behavioral intervention for children who had been sexually abused reported that CBT had moderate efficacy in reducing PTSD and other anxiety symptoms.(46) A randomized trial comparing 8 weeks to 16 weeks of trauma-focused CBT in children found there was little extra improvement with 16 instead of 8 weeks of CBT.(47) [D in Context Link 1, 2, 3]

[E] See Clinical Indications for Admission to Residential Care in this guideline. [E in Context Link 1]

[F] Patient should be observed and safety checks should be performed as often as necessary to minimize risk of harm to self or others.(48) [F in Context Link 1]

[G] Precipitants explain why the admission occurred at the specific point in time. Exploration of all precipitants is essential for treatment and discharge planning.(49) [G in Context Link 1]

[H] PTSD has a high rate of comorbidity with other behavioral health disorders, particularly depressive disorders, substance use disorders, and other anxiety disorders.(30)(50) [H in Context Link 1, 2, 3]

[I] Psychosocial interventions should be individualized, address all admission precipitants and barriers to discharge, and involve family and other supports as necessary.(28) [I in Context Link 1, 2, 3]

[J] Pharmacotherapy should be accompanied by interactive psychoeducation that includes discussion of the course and treatment of PTSD and the potential beneficial and adverse effects of prescribed medication.(28)(29) [J in Context Link 1, 2]

[K] A plan for suicide, homicide, or serious harm to self or another involves more than just the identification of a method to be used, but also consideration of how the means of suicide, homicide, or harm will be acquired and where and when the action will be taken.(48) [K in Context Link 1]

[L] Harm to self or another is considered serious if it has a substantial likelihood of causing death, disability, or major disfigurement. [L in Context Link 1]

[M] A crisis plan establishes what actions the patient and supports are to take if dangerous ideation or behavior develops.(48) [M in Context Link 1, 2]

[N] Diagnostic tests may be performed off-site. [N in Context Link 1]

[O] On the basis of findings from meta-analyses of randomized controlled trials, a practice guideline recommends that an initial trial of trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing for PTSD generally comprise 8 to 12 individual therapy sessions, each up to 90 minutes long, administered by the same therapist, on a weekly or more frequent basis. Hence, in some treatment settings a course of treatment may not be completed but may be planned or initiated.(29) [O in Context Link 1]

[P] Essential functions are those that are necessary to sustain life, such as feeding and hydrating oneself. [P in Context Link 1]

Codes

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ICD-10 Diagnosis: F43.10, F43.11, F43.12
ICD-9 Diagnosis: 309.81
DSM-IV: 309.81

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Residential Acute Behavioral Health Level of Care, Child or Adolescent

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Admission Guidelines

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[Expand All / Collapse All]

- Admission to Residential Acute Level of Care for Child or Adolescent is judged appropriate as indicated by **ALL** of the following [A]:
  - Around-the-clock behavioral care is necessary for treatment because of **1 or more** of the following(4):
    - Imminent danger to self because of **1 or more** of the following(5)(6)(7):
      - Imminent risk for recurrence of Suicide attempt or act of serious self Harm as indicated by **ALL** of the following:
        - Very recent Suicide attempt or deliberate act of serious self Harm
        - Absence of Sufficient relief of the action's precipitants
      - Current plan for suicide or serious self Harm
      - Command auditory hallucinations for suicide or serious self Harm
      - Dangerous behavior risk, persistent Thoughts of suicide or serious Harm to self, or suicide trigger state without formed thoughts, that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B](5)(8):
        - Insufficient child or adolescent behavioral care (eg, facility, provider) availability
        - Severe conflict in family environment or other inadequacy in patient support system
        - Patient characteristics such as high impulsivity, unreliability, or extreme agitation with desperation
        - Ruminative flooding; uncontrollable and overwhelming profusion of negative thoughts
        - Frantic hopelessness; fatalistic conviction that life will not improve along with oppressive sense of entrapment and doom
    - Imminent danger to others due to **1 or more** of the following(9)(10)(11)(12):
      - Imminent risk for recurrence of an attempt to seriously Harm another as indicated by **ALL** of the following:
        - Very recent attempt to seriously Harm another
        - Absence of Sufficient relief of the action's precipitants
      - Current plan for homicide or serious Harm to another
      - Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious Harm to another
      - Persistent thoughts of, or violent impulsive acts that could likely result in, homicide or serious Harm to another that cannot be adequately monitored at lower level of care because of **1 or more** of the following [B]:
        - Insufficient child or adolescent behavioral care (eg, facility, provider) availability
        - Severe conflict in family environment or other inadequacy in patient support system
        - Patient characteristics such as high impulsivity or unreliability
    - Life-threatening inability to receive adequate care from caretakers(9)(11)
    - Severe disability or disorder requiring acute residential intervention as indicated by **ALL** of the following:
      - Severe behavioral health disorder-related symptoms or condition are present as indicated by **1 or more** of the following(2)(3)(9)(13)(14)(15):
        - Major dysfunction in daily living (eg, family, interpersonal, school functioning)
        - Severe problem with cognition, memory, or judgment
        - Severe symptoms (eg, hallucinations, delusions, other acute psychotic symptoms, mania, severe autistic behaviors)(16)(17)(18)
        - Severe behavior risk (affective dysregulation) characteristics indicated by **1 or more** of the following:
          - Evidence of severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
          - Frequent extreme external (extreme angry outbursts) or internal (extreme sulking and rumination) anger manifestations
          - High levels of family conflict
      - Patient management at highest nonresidential level of care has failed or is not feasible until acute intervention or modification is initiated.
    - Severe comorbid substance use disorder that must be controlled (eg, abstinence necessary) to achieve stabilization of primary psychiatric disorder(19)(20)
    - Patient has currently stabilized during inpatient treatment stay for severe symptoms or behavior and requires structured setting with continued around-the-clock behavioral care.
  - No exclusions to treatment: situation and expectations are appropriate for level as indicated by **ALL** of the following(1)(2)(3)(4)(9)(5)(14)(21):

- Recommended treatment is necessary, appropriate, and not feasible at a lower level of care (ie, documented behavior, symptoms, or risk judged not appropriate for partial hospital, IOP, or acute outpatient care).
- Very short-term crisis intervention and resource planning for further care at a nonresidential level is unavailable or judged inappropriate.
- Patient has, at the least, minimal motivation to participate in treatment within a highly structured setting at the direction of parent or guardian.
- No anticipated need for physical restraint, seclusion, or other involuntary control (eg, patient not actively violent)
- No need for around-the-clock medical or nursing care
- Patient has sufficient cognitive capacity to respond to planned individual and group treatment components.(15)
- Adequate response (eg, stabilization for nonresidential level of care) to planned treatment is expected within a limited time period.

Recovery Course

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Stage	Clinical Status	Interventions	Evaluation
1	• **Continued treatment needed for condition as described in Admission Guidelines** • **Treatment plan with goals and progress measurement in place** • **Response to treatment (progress toward goals) is likely**	• **Appropriate crisis management instituted or documented as not needed** • **Ongoing care coordination** • **Ongoing discharge planning** • **Regular safety checks done at appropriate frequency** • **Appropriate treatment plan review**	• **Evaluation completed and reviewed** • **Symptom and functioning assessment at appropriate frequency documented** • **Physician evaluation of patient and progress at appropriate frequency documented** • **Review of need for medication or adjustment at appropriate frequency documented**
2	• **Risk status acceptable** • **Functional status acceptable**	• **Medical needs manageable**	

(2)(3)(4)(5)(15)(22)(23)

Recovery Milestones are indicated in **bold**.

Discharge Guidelines

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[Expand All / Collapse All]

- Continued residential care is generally needed until **1 or more** of the following(21):
  - Residential care no longer necessary due to adequate patient stabilization or improvement as indicated by **ALL** of the following(4)(5)(22):
    - Risk status acceptable as indicated by **ALL** of the following:
      - Patient has not recently made a Suicide attempt or act of serious Harm to self, or has had Sufficient relief of precipitants of any such action.
      - Absence of Current plan for suicide or serious Harm to self for at least 24 hours
      - Thoughts of suicide , homicide, or serious Harm to self or to another are absent or manageable at available lower level of care.
      - Supports, and patient as appropriate, understand follow-up treatment and crisis plan.
      - Provider and supports are sufficiently available at lower level of care.
      - Patient, as appropriate, can participate as needed in monitoring at next level of care.
    - Functional status acceptable as indicated by **1 or more** of the following:
      - No essential function is significantly impaired.
      - An essential function is impaired, but impairment is manageable at available lower level of care.
    - Medical needs manageable as indicated by **ALL** of the following:
      - Adverse medication effects absent or manageable at available lower level of care
      - Medical comorbidity absent or manageable at available lower level of care
      - Substance withdrawal absent or manageable at available lower level of care
  - Residential care no longer appropriate due to patient progress record or consent as indicated by **1 or more** of the following:
    - Patient deterioration requires higher level of care.
    - Guardian no longer consents to treatment.

Care Planning and Evaluation

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- Planning and evaluating appropriate care should address:
  - Evaluation and care needs, which may include(24)(25)(26)(27):
    - Treatments and procedures, including:
      - Psychosocial interventions emphasizing admission precipitants and barriers to discharge

- Cognitive behavioral therapy, interpersonal psychotherapy, or other evidence-based psychosocial therapy appropriate for diagnosis
- Parental component of psychosocial interventions
- Clinical management and psychoeducation if medication is prescribed
- Psychotropic medication if indicated

- Consultation, assessment, and other services, including:
  - Substance abuse assessment(24)
  - Social services consultation for placement or housing
  - Conference with school

- Discharge planning needs, which may include(28):
  - Rapid planning for next level of care; considerations include:
    - Plan for monitoring for dangerous ideation or behavior if necessary
    - Plan for assisting patient with self-care if necessary
  - Aftercare plan development with input from multiple providers, patient, and patient's supports
  - Preparation of patient and supports for transition to next level of care, including:
    - Ensure sufficient knowledge of:
      - Patient's illness
      - Medication
      - Risk factors for relapse
      - Warning signs of relapse
    - Assess ability to attend school, work (as appropriate), and participate in usual activities.
    - Review crisis plan with patient and supports.
  - Follow-up appointments, including:
    - Psychiatrist for pharmacotherapy and clinical management
    - Therapist for cognitive behavioral therapy, interpersonal psychotherapy, or other evidence-based psychosocial therapy appropriate for diagnosis
    - Medical care visit (eg, primary care)
  - Referrals for community assistance and support, including:
    - Self-help or support groups for patient, family, and caregivers
    - Community services for housing, financial, or transportation needs
  - Medications and supplies, including:
    - Psychotropic medications
    - Medications for comorbid medical conditions

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